Civil No: C080895

COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

JACK BAKER

Petitioner,

vs.

WORKERS' COMPENSATION APPEALS BOARD;
SIERRA PACIFIC FLEET SERVICES,

Respondents.

WORKERS' COMPENSATION APPEALS BOARD
WCAB Case No. ADJ8111772

Amicus Curiae Brief Of

CALIFORNIA WORKERS' COMPENSATION INSTITUTE

In Support Of Respondents

SIERRA PACIFIC FLEET SERVICES., STATE COMPENSATION INSURANCE FUND

[Submitted Concurrently With Amicus Curiae Application]

Michael A. Marks, Esq. [SBN 071817]
Law Offices of Allweiss &McMurtry
18321 Ventura Blvd., Suite 500 - Tarzana, CA 91356
Tel: (818) 343-7509

Attorneys for Amicus
California Workers' Compensation Institute

CERTIFICATE OF INTERESTED ENTITIES

Court of Appeal

State of California

Third Appellate District

Court of Appeal Case Number: C080895

Case Name: Jack Baker v. Workers' Compensation Appeals Board of the State of California, Sierra Pacific Fleet Services and State Compensation Insurance Fund

Please check the appropriate box:
x There are no interested entities or persons to list in this Certificate per California Rules of Court, Rule 14.5(d) (3).

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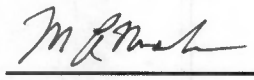
Name of Interested Entity or Person	Nature of Interest

June 3, 2016



Signature of Attorney/Party Submitting Form

Printed Name: Michael A. Marks, Esq. (Allweiss & McMurtry Law Office)
Address: 18321 Ventura Blvd., Suite 50
Tarzana, CA 91356
State Bar No.: 071817

Party Represented: Amicus Curiae – California Workers' Compensation Institute

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VERIFICATION AND WORD COUNT

I, Michael A. Marks, swear that I have read the within Amicus Curiae brief and know the contents thereof; that the within Argument & Authorities contains 9,037 words (including footnotes), based on the automated word count of the computer word-processing program; that I am informed and believe that the facts and law stated therein are true and on that ground allege that such matters are true; that I make such verification because the officers of California Workers' Compensation Institute are absent from the County where my office is located and are unable to verify the petition, and because as their attorney I am more familiar with such facts and law than are the officers.

I declare the truth of the foregoing under penalty of perjury of the laws of the State of California, and that this verification was executed this 3rd day of June, 2016, at Essex, Vermont.

Michael A. Marks (SBN 071817)

DECLARATION OF SERVICE

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT

JACK BAKER

Petitioner

VS.

WORKERS' COMPENSATION APPEALS BOARD, SIERRA PACIFIC FLEET SERVICES and STATE COMPENSATION INSURANCE FUND

Respondent(s)

Civil No: C080895
WCAB Case No. ADJ8111772

Declaration of Service
Via
TrueFiling

I, the undersigned, declare under penalty of perjury that I am a citizen of the United States, over the age of 18, and not a party to the within cause of action. My business address is Allweiss & McMurtry, 18321 Ventura Blvd, Suite 500, Tarzana, CA 91356, and that on June 4, 2016, filing and service of the *Application of California Workers' Compensation Institute for Leave To File Amicus Curiae Brief* AND *Amicus Curiae Brief of California Workers' Compensation Institute* was electronically performed through the TrueFiling electronic system of the court for service pursuant to California Rules of Court 8.70 and 8.71.

Michael A. Marks, Esq.
SBN071817

ARGUMENT & AUTHORITIES

ALTHOUGH ADOPTION OF INDEPENDENT MEDICAL REVIEW IS THE RESULT OF DECADES OF STUDIES AND REFORMS CREATING A MEDICAL DISPUTE RESOLUTION PROCESS THAT IS FASTER, LESS EXPENSIVE, OBJECTIVE AND RESULTS IN HIGHER QUALITY TREATMENT AND BETTER OUTCOMES, THE HISTORICALLY ENTRENCHED SYSTEMIC RESISTANCE TO EVIDENCE-BASED MEDICINE SERIOUSLY UNDERMINES THE LEGISLATIVE INTENT

Group health systems, whether public (i.e., Medicare) or private (Knox-Keene Health Care Service Plan Act of 1975, as amended) have long used managed care / evidence based medicine / utilization review to address issues of medical necessity of treating physician recommendations. But the gradual progression that led up to the revolutionary legislative adoption of "evidence based medicine" as the "gold standard" for medical decision-making in workers compensation, and which elevated industrial medicine to a scientifically based system, was long in coming and not enthusiastically received by a large swath of the workers' compensation community nor judges.

To fully appreciate the extent of the entrenched systemic resistance to implementing evidence-based medicine in workers' compensation requires a bit of history. The resistance likely arises from the fact that since 1975 employees have principally controlled physician selection [stats 1975, ch. 1529, Section 1, amending Labor Code Section 4600(c)][1]. There being no clear statutory or regulatory definition

[1] This was a major shift from the original workers' compensation act which had given employers complete over the selection of medical providers for the life of the claim [stats 1913, Chapter 175, Sec. 15(a)]

of what constitutes "reasonable and necessary medical treatment," disputes were adjudicated using a process that became known as "dueling docs." Over time, this process was found to be time consuming and expensive; often resulting in arbitrary and inconsistent judicial decisions on medical issues, with poor treatment outcomes for workers and employers. In response to studies showing a system plagued with high costs, low benefits, long delays, poor treatment outcomes and endless litigation, the Legislature in 1993 enacted the major reforms which included a presumption of correctness of the findings of the treating physician.[2] The WCAB later broadly interpreted that to be a treating physician presumption of correctness on all medical issues,[3] effectively limiting a payer's ability to challenge treating physician recommendations unless clearly erroneous, incomplete or legally incompetent … a nearly impossible burden.[4] Predictably, what followed was an unprecedented surge in

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[2] CA Labor Code Section 4062.9 [Stats. 1993 ch. 121] (subsequently repealed)

[3] *Minnear v. Mt. San Antonio Community College District* (1996) 61 Cal. Comp. Cases 1055 (Appeals Board en banc opinion)

[4] The theory was that the patient's treating doctor knows what's best. But in a system fraught with misplaced incentives, that theory failed to recognize (a) the unregulated fee-for-service financial incentives to the treating doctors to provide excessive, unnecessary, unproven, ineffective and sometimes harmful forms of care that prolonged work loss time and produced increased permanent disabilities; (b) the employee's and their attorney's financial incentive to use treating physicians describing poorer medical outcomes that increased disability awards and inflated settlements and attorney contingent fees; (c) the greater employer-employee frictional costs from the increasingly contentious adversarial system which produced poorer return-to-work outcomes for employees and thus increased long term economic hardship on workers due to job losses; and (d) that the result would be a system with disproportionately high administrative costs, poorer medical outcomes, relatively low

medical benefit costs. With treating doctors now firmly in control of all medical decision-making, no standard definition of what constituted "reasonable and necessary medical treatment" and no checks and balances, the system became a "blank check" for treating doctors.[5]

The Commission on Health and Safety and Workers' Compensation (hereafter CHSWC) follow-up study the regarding the impact of the 1993 reforms and the treating-physician presumption concluded it was an abysmal failure and recommended it be curtailed.[6] That report states, in its executive summary,

> Numerous parties have challenged the value of the change in the treating physician role and particularly the presumption given to the reports. These complaints generally involve 1) a perception of the low quality of the treating physicians' reports and 2) the problem of poor quality reports being given special authority. Many observers feel that presumption has led to problems

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worker benefit rates, and lengthy delays of benefit determinations with negative impact on medical and vocational rehabilitation.

[5] Between 1996 and 2002, the estimated average ultimate per-claim cost of medical care in indemnity claims increased by an astonishing 267% and studies revealed a clear association between the significant cost increase trend and expansion of the treating physician presumption of correctness on all medically related issues. [Gardner, L., Swedlow, A. The Effect of 1993 – 1996 Legislative Reform Activity on Medical Cost, Litigation and Claim Duration in the California Workers' Compensation System. *Research Note*. CWCI. May 2002]; Neuhauser, F. Doctors and Courts: Do Legal Decisions Affect Medical Treatment Practice? An Evaluation of Treating Physician Presumption in the California Workers' Compensation System. A Report for the California Commission on Health and Safety and Workers' Compensation. November 2002

[6] CHSWC - Report on the Quality of the Treating Physician Reports and the Cost-Benefit of Presumption in Favor of the Treating Physician (August 1999)

> with "doctor shopping" by the party with medical control and increased litigation.
>
> However, quality is only one consideration. The legislation in part meant to reduce the frequency of medical reports by reducing the incentive of any party to request a report from a second (or third) forensic physician. Since the original report by the treating physician is presumed correct, it is less likely that a second report will prevail in a dispute and hence less likely that one will be requested.
>
> ...
>
> In short, changes to the status of the PTP made during the 1993 reforms have resulted in medical-legal decisions based on poorer quality reports without any apparent cost savings. In addition, there is consensus within the [WCAB] that presumption has increased litigation and curtailed the discretion of Workers' Compensation Judges to craft reasonable decisions within the range of evidence.
>
> In view of these findings the preliminary recommendation is to curtail the presumption given to the findings of the primary treating physician.

It was at this point that principles of evidence-based medicine and utilization review began to gain a stronger foothold in workers' compensation. Heretofore, utilization review had been merely permissive, and the resulting reports not admissible into evidence to prove/disprove a medical treatment dispute because they were not reports by a treating physician, and instead the medical-legal dispute mechanism of "dueling docs" under Labor Code Section 4062 was required.[7] But with the 2003 legislation implementing utilization review relying upon evidence-based medicine for determining disputes over medical necessity of treating physician recommendations, the Appeals Board held such reports to be admissible, though not

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[7] *see gen. Czarnecki v. Golden Eagle Insurance Co. (1998) 63 Cal.Comp.Cases 742* (WCAB significant panel decision)

without some reservations about credibility issues and the weight to be assigned such reports.[8],[9]

At the same time, the Legislature first limited the treating physician presumption of correctness and then repealed it altogether, replacing it with a clear definition of what constitutes "reasonable and necessary medical treatment", adopting an objective Medical Treatment Utilization Schedule (MTUS) comprised of medical treatment guidelines using evidence-based, peer reviewed and nationally recognized

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[8] Stats 2003, ch. 639 (SB228); *see also, Willette v. Au Electric (2004) 69 Cal. Comp. Cases 1298 (WCAB En Banc)]*

[9] As summarized in the Legislative Counsel's Digest to SB228 (Stats 2003, Ch. 639), adoption of a medical treatment utilization schedule began with a process for the Commission on Health and Safety and Workers' Compensation to study nationally recognized standards for medical treatment, make recommendations for adoption of such schedules by the Administrative Director, and upon adoption those standards carry a presumption of correctness to be applied in connection with employer utilization review..

CHSWC, at Pgs 5-6 of that report, emphasized the role of mandatory use of evidence-based treatment guidelines as the basis for medical decision-making through the utilization review process, stating as follows:

> The effect of the recommended structure of the guidelines in UR should be to encourage efficient processing of requests for authorization, allowing reviewers to reject treatments that are inconsistent with a clear guideline and putting the burden on the treating physician to document and justify deviations from the guideline. .... If the opinion of the treating physician is not backed by citations to scientific evidence, it may be outweighed by the opinion of a UR physician based on his or her expertise plus references to controlling principles of medicine. Where higher-quality evidence is available, the highest-quality evidence that is applicable to an individual case should determine the treatment.

standards of medical treatment against which treating doctor recommendations in any given case must be evaluated to determine if it was medically appropriate. [10]

Despite having newly defined "medical treatment that is reasonably required to cure or relieve the injured worker" as meaning "treatment that is based upon the guidelines adopted by the administrative director" per Lab. C. 5307.27 and returning

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[10] Assembly Bill 749 (2003) and Senate Bill 899 (2004).; CHSWC summarized the benefits of evidence-based medical decision-making as follows [Evaluating Medical Treatment Guideline Sets for Injured Workers in California (2005) *prepared by RAND Institute for Civil Justice, at the request of CHSWC*, Pg. 10,11)

> "… physicians and other health care professionals are relying more and more upon evidence from clinical research studies to support their diagnostic and therapeutic choices. Within health care, this represents "a significant cultural shift, a move away from unexamined reliance on professional judgment toward more structured support and accountability for such judgment" (Field and Lohr, 1990).
>
> Use of the best available evidence to support medical professionals' decision-making is often referred to as evidence-based medicine (Sackett et al., 1996), the objective of which has been defined as "to minimize the effects of bias in determining an optimal course of care" (Cohen, Stavri, and Hersh, 2004). Bias, meaning lack of objectivity and other factors that may distort conclusions, can exist at any stage in the medical decisionmaking process, from research through guideline development and clinical care.
>
> There are many sources of bias in evaluating tests and therapies. Preconceived notions on the part of sponsors, researchers, and participants can influence the apparent efficacy of a therapy. Baseline patient characteristics, the natural course of illness, and chance may suggest an effect when there is none, or the absence of an effect when one exists. These problems can be alleviated by careful study design, particularly by the gold-standard design: the randomized controlled trial. In randomized controlled trials, participants are randomly assigned to receive either the therapy under study or a comparison therapy, which can be an accepted therapy or a placebo. While weaker designs can also mitigate bias, they often do so incompletely (Campbell and Stanley, 2005)

of medical treatment to the employer through Medical Provider Networks,[11] disputes continued to be adjudicated through the same "dueling docs" process that was still considered too lengthy, expensive, and an often unsatisfactory path for injured workers and claims administrators. Many felt that expert witnesses and the decisions of judges often failed to adequately consider and apply the statutory guidelines, and consequently that the opinion of the judge routinely failed to enforce the statutorily mandated medical criteria of "evidence-based medicine".

The workers' compensation judiciary's resistance, as manifested by inconsistent and unpredictable enforcement of evidence-based treatment guidelines,[12] further undermined the legislative purposes behind adoption of the Medical Treatment Utilization Schedule and undoubtedly encouraged even more litigiousness.

Against this backdrop, in 2011 CHSWC studies recommended use of independent medical review to resolve treatment disputes that continued despite the employer's utilization review processes, noting that,

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[11] *See* Labor Code Section 4600(c), 4604.5 and 4610, et seq. establishing employer's right to create a Medical Provider Network of exclusive providers of medical treatment unless the employee had pre-designated his/her personal physician.

[12] *Compare* , *Lamin v. City of Los Angeles* (2004) 69 Cal.Comp.Cases 1002 (Appeals Board panel decision); *Los Angeles Times v. Workers' Comp. Appeals Bd. (Herbinger)* (2005) 70 Cal.Comp.Cases 504, writ denied; *Regents of the University of California v Workers' Comp. Appeals Bd. (Macari)* (2005) 70 Cal.Comp.Cases 1733, writ denied; *ICW Group/Explorer Insurance Co. v. Workers' Comp. Appeals Bd. (Ulloa)* (2005) 70 Cal.Comp.Cases 1176, writ denied.

> …external review of medical-necessity issues could reduce the complexity of California's dispute-resolution process, increase the timeliness and appropriateness of medical necessity appeal determinations, and reduce medical cost-containment expenses. There are various models that use external review organizations in deciding medical-necessity disputes. **Timely and impartial independent medical review (IMR) decisions would improve the quality of medical-necessity decisions because such issues would be decided by medical experts instead of judges** in an administrative process.[13]

A series of studies found that although the implementation of the MTUS and Medical Provider Networks were associated with an initial overall reduction of medical treatment and frictional costs, this was short-lived. Those reforms also were associated with an immediate and sustained increase in employer medical cost containment expenses (i.e., utilization review and bill review), a form of frictional cost, which nearly tripled between 2002 and 2010.[14] In addition, inconsistent decisions by the WCAB on application of the MTUS and medical billing issues cast doubt on whether non-medical adjudicators such as judges were the optimal choice for medical dispute resolution.

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[13] Medical Care Provided Under California's Workers' Compensation Program: Effects of the Reforms and Additional Opportunities to Improve the Quality and Efficiency of Care, CHSWC 2011 Report, Summary at Pgs. xviii-xxvix,(emphasis added).

CHSWC analysis of IMR was in part based on the existing model within California's group health system and Medicare (id, at fn. 11 and accompanying text). The group health system's IMR contractor is Maximus, who is also contracted by Medicare and by the Division of Workers' Compensation herein.

[14] Ireland, J., Swedlow, A., Gardner, L. Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System. CWCI, June 2013.

In response to the 2011 CHSWC recommendations regarding independent medical review and independent bill review, in late 2012 another round of reforms began to take shape in the form of Senate Bill 863, which adopted Independent Medical Review for medical decision-making in lieu of judges and lawyers. In section 1 of SB 863, the Legislature expressly stated the rationale for creating Independent Medical Review as follows:

> (d) That **the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers** injured in the course of employment.
>
> (e) That **having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care** and that the provision of the act establishing independent medical review are necessary to implement that policy.
>
> (f) That the performance of independent medical review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that **independent medical review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code that will be more expeditious, more economical, and more scientifically sound than the existing function** of medical necessity determinations .... **The existing process ... is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of ... evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise** ....
>
> (g) That the establishment of independent medical review and **provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws**

of this state and to control the manner of review of such decisions. (SB863, Stats 2012, Ch. 363, emphasis added)

In its annual report for 2012, CHSWC described the impact of the new independent medical review component of SB863, comparing the then-current system with the new system, as follows:

> **Under the current system, it typically takes nine to 12 months to resolve a dispute over the treatment needed for an injury**. The process requires: (1) negotiating over selection of an agreed medical evaluator; (2) obtaining a panel, or list, of state-certified medical evaluators if agreement cannot be reached; (3) negotiating over the selection of the state-certified medical evaluator; (4) making an appointment; (5) awaiting the examination; (6) awaiting the evaluator's report, and then if the parties still disagree; (7) awaiting a hearing with a workers' compensation judge; and (8) awaiting the judge's decision on the recommended treatment. In many cases, the treating physician may also rebut or request clarification from the medical evaluator, and the medical evaluator may be required to follow up with supplemental reports or answer questions in a deposition.
>
> **SB 863 replaces those eight steps with an IMR process similar to group health that takes approximately 40 (or fewer) days to arrive at a determination so that the appropriate treatment can be obtained**. IMR can only be requested by an injured worker following a denial, modification, or delay of a treatment request through the utilization review (UR) process. Employers and insurance carriers cannot request review of treatment authorizations.
>
> An injured worker can be assisted by an attorney or by his or her treating physician in the IMR process. There is a right to appeal an IMR determination, to the trial level WCAB, on the basis of fraud, conflict of interest, or mistake of fact. The reviewer's underlying medical decision-making, however, cannot be overturned by a judge. The remedy, if an appeal is granted, is referral to a different reviewer for another review. (emphasis added)

As noted in the legislative history[15], the intent behind adoption of independent medical review with limited appellate review was as follows:

> SB 863 proposes to change the way medical disputes are resolved. Currently, when there is a disagreement about medical treatment issues, each side attempts to obtain medical opinions favorable to its position, and then counsel for each side tries to convince a workers' compensation judge based on this evidence what the proper treatment is. **This system of "dueling doctors" with lawyers/judges making medical decisions has resulted in an extremely slow, inefficient process that many argue does not provide quality results. Long delays in obtaining treatment result in poorer outcomes, reduced return to work potential, and excessive costs in the system, none of which are good for injured workers. SB 863 would instead adopt an independent medical review system patterned after the long-standing and widely applauded IMR process used to resolve medical disputes in the health insurance system**. Thus, a conflict- free medical expert would be evaluating medical issues and making sound medical decisions, based on a hierarchy of evidence-based medicine standards drawn from the health insurance IMR process, with workers' compensation-specific modifications. The bill contains findings that this system would result in faster and better medical dispute resolution than existing law.
>
> The IMR system is designed to ensure that medical expertise is used to resolve medical disagreements. Thus, the decision from the IMR is final and binding on the parties. Nonetheless, in the exercise of the Legislature's plenary authority to establish a workers' compensation system that includes a review of decisions**, there is a process to appeal the IMR result, but this review process does not allow the second-guessing of medical expertise.** Rather, the appeal is limited to circumstances where there was fraud, conflict of interest, discrimination based on protected classes, or clear mistakes of facts that do not involve medical expertise.

The procedural changes in the medical treatment dispute resolution process as embodied within SB863 thus reflect the legislature's adoption of the CHSWC solution to a medical treatment delivery and dispute resolution system that took 9-12

[15] Assembly Committee on Insurance, August 31, 2012 Hearing

months, was a cumbersome 8-step process, and too often produced inconsistent results divorced from the highest quality medical care evidence-based treatment guidelines with proven effectiveness. Nonetheless, there remains an entrenched bias against Independent Medical Review, as is evident from efforts by some adjudicators to reinvest the Appeals Board with original jurisdiction over UR and IMR determinations despite the statutory changes.[16], [17]

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[16] Efforts to circumvent UR by WCAB asserting original jurisdiction over treatment disputes are apparent from *Gomez v. Facilities Support* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 149, *Weilman v. United Temporary Services* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 163, *Page v. Barman Transport* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 177, *Tabaracci v. Waste Management* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 182 Those decisions had relied upon *Dubon v. World Restoration, Inc.*, (2014) 79 Cal. Comp. Cases 313 (so-called *Dubon I*, which was subsequently reversed by the WCAB in its En Banc decision in *Dubon v. World Restoration, Inc.*, (2014) 79 Cal. Comp. Cases 1298.(so-called *Dubon II*).

[17] Though *Dubon II* has largely squelched the UR rebellion, the litigation "whack-a-mole" has merely resurfaced in similar efforts to circumvent IMR by WCAB asserting original jurisdiction over treatment disputes in numerous cases similar to the one currently under consideration by this Court [see, numerous appellate decisions and pending appellate cases in *Ramirez v. WCAB (Calif. Dept of Health Care Services) (2015); McFarland v. WCAB* (2015) (First Appellate District No. A144561); *Stevens v. WCAB & Outspoken Enterprises* (2015) (First Appellate District No. A141435), *Hallmark Marketing v. WCAB (Southard)* (2015) (Third Appellate District No CO79912)]; *California Highway Patrol, et al v. WCAB (Margaris)* (2016) [Second Appellate District No. B269038; *Zuniga v. Interactive Trucking* (First Appellate District No. A143290)]

THE TIME FOR AN IMR DECISION UNDER LABOR CODE SECTION 4610.6(d) IS DIRECTORY ONLY, THUS NOT GROUNDS FOR INVALIDATING THE IMR DECISION.

A This Court Should Follow the First Appellate District – Division 1 Opinion in *Stevens v. Workers' Comp. Appeals Bd.* Finding Labor Code Section 4610.6(d) to be Directory Only, Thus NOT Vesting the WCAB With Original Jurisdiction to Decide the Disputed Medical Issue

The fundamental issue presented herein is whether the time for the Administrative Director of the Division of Workers' Compensation to issue an Independent Medical Review decision under Labor Code Section 4610.6(d) is mandatory or directory. *In Stevens v. Workers' Comp. Appeals Bd., 241 Cal. App. 4th 1074, 194 Cal. Rptr. 3d 469 (review denied 2/17/16)*, (hereafter referred to as *Stevens*) the First Appellate District – Division 1recently addressed the very question presented herein regarding failure of the IMR determination to issue within the 30 days as set forth in Labor Code Section 4610.6(d). In that published opinion, the Court held that,

> In its final decision, the Board noted that Stevens's (sic) IMR determination took over seven months and found fault with the lack of a statutory mechanism to enforce section 4610.6, subdivision (d)'s requirement that IMR determinations be made within 30 days… **In the absence of a penalty, consequence, or contrary intent, a time limit is typically considered to be directory, and its violation does not require the invalidation of the action to which the time limit applies**. (See, e.g., *California Correctional Peace Officers Assn. v. State Personnel Bd. (1995) 10 Cal.4th 1133, 1145 [43 Cal. Rptr. 2d 693, 899 P.2d 79].*)

For the reasons outlined below, that published decision correctly resolves the conflicting Appeals Board decisions on this subject. Consistent with that opinion, this Court should similarly find the Section 4610.6(d) time limits merely directory.

B LABOR CODE SECTION 5313 PROVISION REGARDING A WCAB JUDGE'S TIME TO ISSUE AN OPINION HAS BEEN INTERPRETED AS DIRECTORY, AND THIS COURT SHOULD APPLY LONGSTANDING RULES OF STATUTORY CONSTRUCTION TO SIMILARLY INTERPRET LABOR CODE SECTION 4610.6(d) AS DIRECTORY

The basic rules of statutory construction were succinctly summarized in *City of Martinez v. WCAB* (2000) 85 Cal. App. 4th 601, 616, as follows:

> The fundamental rule is to ascertain and effectuate the intent of the Legislature in enacting the statutes. (*Moyer v. Workmen's Comp. Appeals Bd.*, *supra*, 10 Cal. 3d 222, 230.) In determining the intent, we examine first the words of the statutes. (*Id.* at p. 231.) Words, however, do not have fixed meanings; they are symbols of thought whose meanings may vary depending upon the context and circumstances in which they are used. (*Henry v. Workers' Comp. Appeals Bd.* (1998) 68 Cal. App. 4th 981, 984 [80 Cal. Rptr. 2d 631].) We consider the consequences of our interpretation and avoid constructions that defy common sense, frustrate the apparent intent of the Legislature or might lead to absurdity. (*Id.* at p. 985.) HN16 **It is presumed the Legislature is aware of the existence of all relevant statutes when it considers a change or amends others.** (*Nickelsberg v. Workers' Comp. Appeals Bd.* (1991) 54 Cal. 3d 288, 298 [285 Cal. Rptr. 86, 814 P.2d 1328].) The statutes "should be interpreted in such a way as to make them consistent with each other, rather than obviate one another."

As articulated in *Jiminez v. San Joaquin Valley Labor* (2002) 67 Cal. Comp. Cases 74, 83 (Appeals Bard *en banc*)

> **[i]n enacting legislation, the Legislature is presumed to have knowledge of existing judicial decisions ... and to have adopted or amended statutes in light of such decisions**. (*Bailey v. Superior Court* (1977) 19 Cal.3d 970, 977, fn. 10 [568 P.2d 394, 140 Cal. Rptr. 669]; *Clark v. Workers' Comp. Appeals Bd.* (1991) 230 Cal.App.3d 684, 695-696 [281 Cal. Rptr. 485] [56 Cal. Comp. Cases 331, 340]; *Barragan v. Workers' Comp. Appeals Bd.* (1987) 195 Cal.App.3d 637, 650-651 [240 Cal. Rptr. 811][52 Cal. Comp. Cases 467, 478]; *Ezzy v. Workers' Comp. Appeals Bd.* (1983) 146 Cal.App.3d 252, 261, fn. 4 [194 Cal. Rptr. 90][48 Cal. Comp. Cases 611, 616, fn. 4].) (emphasis added)

Moreover, *In re Jerry R.,* (1994) 29 Cal. App. 4th 1432, 1437 underscores the importance of consistency of interpretation of similar statutes within the same statutory scheme, observing that

> Statutes are not to be read in isolation, but must be construed with related statutes. (*People* v.*Craft, supra,* 41 Cal. 3d at p. 560.) **When legislation has been judicially construed and a subsequent statute on a similar subject uses identical or substantially similar language, the usual presumption is that the Legislature intended the same construction,** unless a contrary intent clearly appears. (*Malcolm* v. *Superior Court* (1981) 29 Cal. 3d 518, 527-528 [174 Cal. Rptr. 694, 629 P.2d 495]; *Los Angeles Met. Transit Authority* v.*Brotherhood of Railroad Trainmen* (1960) 54 Cal. 2d 684, 688 [8 Cal. Rptr. 1, 355 P.2d 905].)

In the context of the statutory scheme and consistency of interpretation of similar Labor Code sections, at least four cases address a situation directly analogous to the one presented herein. Those interpret the Labor Code's 30 day time provision for a WCAB Judge to issue an award as directory. In *Coombs v. Industrial Acc. Com., (1926) 76 Cal.App. 565 [245 P. 445]*, the 30 days to issue an award under the Workmen's Compensation Act, [Cal. Gen. Laws, Act 4749, Section 20(a) (the precursor of Labor Code Sectiono 5313)] was held to be directory only. In *Peak v. Industrial Acc. Com., (1947) 82 Cal.App.2d 926 [187 P.2d 905]*, the contention that failure to make a decision within the 30 days deprived the commission of jurisdiction was rejected, with the Court calling the contention "absurd". [Id, at 932] The Court in *Janet* v. *Industrial Acc. Com.* (1965) 238 Cal.App.2d 491, 497 specifically rejected the contention that the time limit is jurisdictional and thus an award beyond that time limit is invalid. Even in the face of Labor Code Sections 5313 and 5800.5 making such time limit mandatory and not merely directive, the Court held that the parties' remedy for such a delay is a writ

of mandamus, but does not invalidate the decision.[18] Similarly, in *Liberty Mutual Ins. Co v. IAC* (1964) 231 Cal. App. 2d 501 the Court also rejected the contention that an award issued beyond the 30 day provision was invalid.

Furthermore, the Legislature has expressed a consequence of tardy action on the part of the Appeals Board itself. Labor Code Section 5909 expressly states that where the Appeals Board fails to take action on a Petition for Reconsideration within 60 days, the petition is deemed denied, thus paving the way for appellate court jurisdiction via writ of review under Labor Code Section 5950. In the IMR context, there being no similar express grant of Appeals Board jurisdiction to hear the issue based upon a late IMR decision, this Court should not acquiesce to the "wack-a-mole" efforts to undo the legislative decision that medical decisions not be made by lawyers and judges.

Applying the above referenced canons of legislative interpretation regarding a subsequent statute on a similar subject, the Legislature is presumed to have been aware of this prior directory construction of the similar statute when it enacted the decision timeframe for IMR using substantially the same language and in not enacting a consequence to the late conduct [unlike Labor Code Sectio 5909]. Therefore, this Court should agree with the First Appellate District's recent conclusion in *Stevens*, finding 4610.6(d) directory only.

[18] There is a consequence to the Judge, as 8 CCR 9713 prohibits a WCAB judge from being paid if any decisions are outstanding more than 90 days.

C. THE CONSEQUENCE OF FINDING LABOR CODE SECTION 4610.6(d) MANDATORY WOULD BE TO DEPRIVE THE INJURED WORKER OF ANY STATUTORILY PERMITTED AVENUE TO CHALLENGE AN ADVERSE UTILIZATION REVIEW DECISION.

As shown in more detail below, under the statutory scheme, an employer's adverse Utilization Review decision may *only* be challenged via Independent Medical Review [Labor Code Section 4610.5(e)]. The Appeals Board lacks jurisdiction to review an employer's timely Utilization Review determination, *except* via an appeal of an Independent Medical Review decision. Therefore, a finding that there is no IMR decision to review (because the timeframe is mandatory) would deprive the injured worker of any statutorily permitted means to challenge the employer's adverse UR decision.

The process for addressing medical treatment disputes between the employee and the employer is governed by multiple interrelated Labor Code sections that have been reformed by the legislature on numerous occasions to expedite and improve the quality of treatment and medical decision-making.[19] Labor Code Section 4600 defines the employer obligation and corresponding employee entitlement to "medical treatment that is reasonably required" as in accordance with the "guidelines adopted by the administrative director pursuant to Labor Code Section 5307.27" [Labor Code Section 4600(b)]. To effectuate compliance with those statutory treatment guidelines, Labor Code Section 4610 requires all employers to establish a rigidly prescribed utilization review process to be applied in all cases [*see gen, State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Sandhagen)*

[19] For the evolution of the medical treatment dispute process, *see gen State Comp. Ins. Fund v. Workers' Comp. Appeals Bd.* (*Sandhagen*) (2008) 44 Cal. 4th 230, 237-245, [79 Cal. Rptr. 3d 171, 186 P.3d 535, 73 Cal. Comp. Cases 981], *and see*, *Dubon v. World Restoration* (2014) 79 Cal. Comp. Cases 1298 (Appeals Board *en banc) (Rev. den)*

(2008) 44 Cal. 4th 230]. Labor Code Section 4610.5 expressly limits an employee's appeal of an adverse utilization review decision as via Independent Medical Review. That section specifically states,

> *A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section.* Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section. (Labor Code Section 4610.5(e), emphasis added)

Any doubt that the Appeals Board lacks jurisdiction to directly review a utilization review decision is conclusively put to rest when one recognizes that in 2012, when the legislature enacted Independent Medical Review as part of SB 863 (Stats. 2012, ch. 363.), the legislature also amended the jurisdictional provisions of Labor Code Section 4604 to limit the Appeals Board's jurisdiction.[20] Under that amendment, the Appeals Board expressly no longer has jurisdiction to review a medical treatment dispute arising from an employer's utilization review determination *except* as an appeal from an independent medical review determination under Labor Code Section 4610.5. If there is no IMR decision to appeal (i.e., tardy action by the Administrative Director produces no valid decision via IMR), the employee would be left without a remedy through no fault of his own.

Such a possibility, that a litigant could be left with no remedy due to an administrative tribunal's error of timing, thus depriving the aggrieved party of his appeal through no fault of his own, has been considered numerous times and

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[20] Labor Code Section 4604 states, "Controversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party, *except as otherwise provided by Section 4610.5*." (emphasis added)

rejected in favor of finding such time limits merely directory. For example, in *Edwards v. Steele* (1979) 25 Cal. 3d 406 (rejecting the contention that untimely action on a zoning board appeal invalidates the action), the Court observed,

> The probable intent underlying the ordinance was to assure *to the aggrieved party* a reasonably timely hearing of, and decision on, his administrative appeal. To hold that the provisions are mandatory and jurisdictional under the circumstances of the present case would seemingly defeat the foregoing purpose by depriving the aggrieved party of his appeal through no fault of his own. Moreover, no "consequence or penalty" for noncompliance with the time limitations is contained in the ordinance, and nothing in the language thereof suggests an intent to nullify a timely filed appeal solely because the board has delayed in acting thereon. [Id, at 410]
>
> Several appellate cases have recognized that it would be improper, or even unconstitutional, to hold that an administrative board's failure to act within the period prescribed by statute or ordinance divests a board of its jurisdiction to rule upon a timely appeal [Id, at 411 (*citations omitted*)]
>
> … seemingly mandatory language need not be construed as jurisdictional where to do so might well defeat the very purpose of the enactment or destroy the rights of innocent aggrieved parties. In other words, the provision at issue may be considered mandatory only in the sense that the board "could be mandated to act if it took more time than the short period allotted." (*Liberty Mut. Ins. Co., at p. 510* [interpreting the seemingly mandatory language of the 30-day limitation in *Lab. Code, § 5313*]; see also *McDonald's Systems of California, Inc., v. Board of Permit Appeals, supra, 44 Cal. App. 3d at p. 541.*) [Id, at 412 (citations omitted)]

Similarly, in *California Correctional Peace Officers Assn. v. State Personnel Board* (1995) 10 Cal. 4th 1133, the Court interpreted the Government Code section 18671 requirement that a decision be rendered within the statutory 6-month time frame as directory, not mandatory, and that "The Board retains jurisdiction over the employee's appeal notwithstanding its failure to render a decision within the statutory time limits.." [Id, at 1138]. And in *Chrysler Corp. v. New Motor Vehicle*

Board (1993) *12 Cal. App. 4th 621* the Court held that the 30-day time limit to issue a decision under Veh. Code, § 3067 is directory only, noting that otherwise "the Protesting Parties would have a decision against them imposed through no fault of their own by means of a totally mechanical application of the time limit in the statute" [Id, at 630-631]

Reading the statutory scheme as a whole, Sections 4604 expressly limits the Appeals Board's jurisdiction over medical treatment disputes to that of an appeal of an IMR determination issued under 4610.5. The grounds for appeal are limited by statute to those grounds specified in 4610.6(h), none of which relates to compliance with the 30-day time directive. Thus there is no statutory basis for the WCAB to assert jurisdiction with regard to the 30-day time directive. Even where the Administrative Director's IMR decision is overturned on one of the statutory grounds, Labor Code Section 4610.6(i) expressly prohibits the appellate body (whether judge, appeals board or court) from making its own decision on the merits of the medical necessity issue,[21] instead limiting the remedy to sending the matter back to the Administrative Director for a new IMR.[22] Therefore, a WCALJ, the Appeals Board and the courts lack jurisdiction to issue their own decision on the merits of the medical necessity dispute. Lacking such jurisdiction on appeal, the party aggrieved by the adverse IMR decision would be without a remedy.

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[21] Labor Code Section 4610.6(i) states, "In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization."

[22] In this regard, Labor Code Section 4610.6(i) states, "If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization."

Such an outcome was expressly considered by the court in *Liberty Mutual Ins. Co v. IAC* (1964) 231 Cal. App. 2d 501 which rejected the contention that a WCAB award issued beyond the 30 day provision was invalid, noting that

> In many cases to interpret the statutory language as we are urged to do would be to declare that through failure to act the jurisdiction of the commission to make any award at all would be lost, and this without any fault of the party seeking relief. **By the mere inaction of the commission a right would be denied, the aggrieved party being helpless to prevent in any way the complete denial of his right**. ... If the Legislature had intended to work so monstrous a result, it surely ought to have said so by language specifically declaring such intent. It did not do so. We hold that the commission did not lose jurisdiction and that the award it made was valid notwithstanding the failure to obey the statutory mandate respecting the time within which it ruled after submission. We think the Legislature, concerned with complaints of delay in theof (sic) Industrial Accident Commission cases, intended only to place the commission in such a position that it could be mandated to act if it took more time than the short period allotted. But that the Legislature intended to destroy rights is incredible. (Id, at 509-510)

As may be inferred from the decision in *Stevens,* the proper procedure to be followed when the IMR decision time was not met would have been either to file a Writ of Mandate to compel a decision or to request the AD to assign the matter to a different IMR due to non-compliance by the first assignee. Instead, what the claimant seemingly did is wait for the decision and only challenged the process upon learning the IMR decision was adverse.[23],[24]

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[23] In an analogous circumstance where a Qualified Medical Evaluator (QME) appointed by the Division of Workers Compensation fails to issue a medical report within the 30 day time frame allowed by Labor Code § 139.2(j)(1), the Appeals Board in *Fajardo v. W.C.A.B. (2007) 72 Cal. Comp. Cases 1158* (writ denied) and *County of Sonoma v. W.C.A.B. (Smith) (2008) 73 Cal. Comp. Cases 268* (writ denied), held that, in order to obtain a replacement QME panel due to a QME's failure to timely issue a report, a party must object and request a new panel prior to

Given the express jurisdictional limits of the Appeals Board with regard to medical treatment disputes as outlined above, this Court can best preserve both the parties' appellate rights and the legislative intent by finding that Labor Code Section 4610.6(d) is directory, and that appeals must accord with the provisions of Labor Code Section 4610.6(h). We therefore urge this Court to find in accord with the *Stevens,* that the time limit is directory only, thus not vesting the WCAB with jurisdiction to decide the disputed medical issue.

D. BECAUSE THERE IS NO STATUTORY CONSEQUENCE NOR PENALTY ENACTED FOR THE FAILURE OF THE ADMINISTRATIVE DIRECTOR TO ISSUE ITS IMR FINDINGS WITHIN THE PRESCRIBED TIME FRAME, SUCH TIME SHOULD BE DEEMED DIRECTORY ONLY, IN ACCORD WITH THE GENERALLY ACCEPTED RULE OF STATUTORY INTERPRETATION

Where there is a lack of consequence or penalty for an administrative body's failure to meet a time frame, that time frame is generally held to be directory only. For example, in *McDonald's Systems of California, Inc. v. Board of Permit Appeals* (1975) 44 Cal. App. 3d 525 the Court found a permit appeal decision rendered beyond the municipal code's 40 day requirement to be directory only. In so doing, the Court (Id., at fn. 15) referenced the following in support of that conclusion:

> In *Garrison v. Rourke (1948) 32 Cal.2d 430 [196 P.2d 884]* [overruled on another issue *Kean v. Smith (1971) 4 Cal.3d 932, 939 (95 Cal.Rptr. 197, 485 P.2d 261)*], it was contended that the trial court lost jurisdiction to enter a

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receipt of the report, thereby avoiding any gamesmanship. That same rationale should be applied herein, to avoid "doctor shopping" through the IMR process based on a belatedly raised timing technicality.

[24] One can only speculate whether claimant would be taking the same position herein if the IMR decision had been adverse to the employer who then sought to have it voided on "mandatory" grounds.

judgment in favor of the contestant because the court did not file its findings of fact and conclusions of law "within ten days after the submission" of the case as prescribed by former section 8556 [now § 20086] of the Elections Code. The court ruled as follows: "*Section 5 of Article VI of the Constitution* of this state [citation] and article 3, chapter 2, division 10 (§§ 8550-8557) of the Elections Code, vest in the superior court jurisdiction to hear and determine election contests, and to confirm or annul a contested election, or to declare that some other person has been elected. The jurisdiction thus vested may not lightly be deemed to have been destroyed. **The intent to divest the court of jurisdiction by time requirements is not read into the statute unless that result is expressly provided or otherwise clearly intended**. The consequence or penalty for the failure of the court to file findings of fact and conclusions of law within the designated period was not included in the statute. The defendant does not present a case where such a result ensued in the absence of the express requirement. That it was not to occur unless expressly provided is demonstrated by the fact that **when the Legislature wished to indicate that intent it adopted the simple expedient of including an express provision to that effect.** (See *Code Civ. Proc., § 660*, limiting the time for passing upon a motion for new trial; *Code Civ. Proc., § 657*, limiting the time when the court may file an order specifying insufficiency of the evidence as a ground for granting new trial.) The case of *Thomas v. Driscoll, 42 Cal.App.2d 23* . . . involved *section 657 of the Code of Civil Procedure*, and **the correct rule is indicated in that decision as follows: A time limitation for the court's action in a matter subject to its determination is not mandatory (regardless of the mandatory nature of the language), unless a consequence or penalty is provided for failure to do the act within the time commanded.**" (*Id., at pp. 435-436.* See *Steen v. City of Los Angeles (1948) 31 Cal.2d 542, 545-546 [190 P.2d 937]*; and *Cook v. Civil Service Commission (1960) 178 Cal.App.2d 118, 128-130 [2 Cal.Rptr. 836]* [tardy action by civil service commission]; *Farmers etc. Nat. Bank v. Peterson (1936) 5 Cal.2d 601, 607 [55 P.2d 867]*; and *City of Los Angeles v. Hannon (1926) 79 Cal.App. 669, 673-674 [251 P. 247]* [failure of court to file decision within time prescribed by Code of Civil Procedure]; *Buswell v. Board of Supervisors (1897) 116 Cal. 351, 354 [48 P. 226]* [equalization of taxes after time prescribed, but within time which could have been but was not intended]; *Janet* v. *Industrial Acc. Com.* (1965) 238 Cal.App.2d 491, 497 [47 Cal.Rptr.

829]; *Liberty Mut. Ins. Co. v. Ind. Acc. Com. (1964) 231 Cal.App.2d 501, 508-510 [42 Cal.Rptr. 58]*; *Peak v. Industrial Acc. Com. (1947) 82 Cal.App.2d 926, 932 [187 P.2d 905]*; and *Coombs v. Industrial Accident Com. (1926) 76 Cal.App. 565, 569 [245 P. 445]* [failure to make award under Workmens' Compensation Act within 30 days after the case is submitted]; *Anderson v. Pittenger (1961) 197 Cal.App.2d 188, 193-194 [17 Cal.Rptr. 54]* [city council's tardy denial of a variance on review of planning commission's grant]; *Koehn v. State Board of Equalization (1958) 166 Cal.App.2d 109, 118-119 [333 P.2d 125]* [failure of A.B.C. Appeals Board to enter order within time prescribed]; *Barry v. Contractors State License Board (1948) 85 Cal.App.2d 600, 607 [193 P.2d 979]* [failure of hearing officer to enter decision within time prescribed]; and *Bernardo v. Rue (1914) 26 Cal.App. 108, 110 [146 P. 79]* [failure to file findings and judgment in election contest within time prescribed].)

The legislature clearly knows how to specify a consequence or penalty, as it has done so in numerous instances..[25] The Labor Code clearly provides no consequence or penalty for the Administrative Director's failure to issue IMR findings within the statutory time frame. Consistent with the principle discussed

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[25] Examples of the legislature specifying a consequence or penalty for untimely action by a tribunal include the following: CCP 629(b) ["The power of the court to rule on a motion for judgment notwithstanding the verdict shall not extend beyond the last date upon which it has the power to rule on a motion for a new trial. If a motion for judgment notwithstanding the verdict is not determined before that date, the effect shall be a denial of that motion without further order the court."] CCP 630(f) ["the power of the court to act under the provisions of this section shall expire 30 days after the day upon which the jury was discharged, and if judgment has not been ordered within that time the effect shall be the denial of any motion for judgment without further order of the court."]; CCP 663a(b) ["the power of the court to rule on a motion to set aside and vacate a judgment shall expire 60 days from the mailing of notice of entry of judgment by the clerk of the court pursuant to Section 664.5, or 60 days after service upon the moving party by any party of written notice of entry of the judgment, whichever is earlier, or if that notice has not been given, then 60 days after filing of the first notice of intention to move to set aside and vacate the judgment. If that motion is not determined within the 60-day period, or within that period, as extended, the effect shall be a denial of the motion without further order of the court"].

above, the Court in *Stevens* held the time provision of Labor Code Section 4610.6(b) to be directory only, noting that

> In the absence of a penalty, consequence, or contrary intent, a time limit is typically considered to be directory, and its violation does not require the invalidation of the action to which the time limit applies. (See, e.g., *California Correctional Peace Officers Assn. v. State Personnel Bd.* (1995) 10 Cal.4th 1133, 1145.)

We therefore urge this Court to find in accord with the decision in *Stevens*, finding 4610.6(d) time provisions directory only..

E. THE PETITIONER'S INTERPRETATION OF LABOR CODE SECTION 4610.6(d) WOULD FRUSTRATE THE CLEAR LEGISLATIVE INTENT OF INDEPENDENT MEDICAL REVIEW THAT MEDICAL DECISIONS BE MADE BY QUALIFIED INDEPENDENT PHYSICIANS THROUGH AN ADMINISTRATIVE PROCESS, RATHER THAN AN ADVERSARY PROCESS

The legislative history of adoption of Independent Medical Review in 2013 was summarized by the court in *Stevens*, wherein it was pointed out that the 2004 workers compensation reforms requiring employer utilization review based on uniform medical treatment guidelines were intended to transfer initial medical decision-making from the lay claims adjuster to qualified medical professionals competent to evaluate the clinical issues involved [26] but otherwise left the traditional adversary process intact. Further reforms effective in 2013 adopted Independent Medical Review instead of the traditional adversary process, and the legislative history makes it clear that the rationale was as follows:

> (d) That the current system of resolving disputes over the medical necessity of requested treatment is costly, time consuming, and does not uniformly result in

[26] *2015 Cal. App. LEXIS 968*

the provision of treatment that adheres to the highest standards of evidence-based medicine, adversely affecting the health and safety of workers injured in the course of employment.

(e) That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy.

(f) … that independent medical review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code that will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators appointed pursuant to Section 139.2 of the Labor Code. The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists that are not available through the civil service system.

(g) That the establishment of independent medical review and provision for limited appeal of decisions resulting from independent medical review are a necessary exercise of the Legislature's plenary power to provide for the settlement of any disputes arising under the workers' compensation laws of this state and to control the manner of review of such decisions. (SB863, Stats 2012, Ch. 363, section 1 , emphasis added)

As confirmed in the legislative committee hearings[27], the intent behind adoption of IMR and substantially restricting the role of the WCAB was as follows:

SB 863 proposes to change the way medical disputes are resolved. Currently, when there is a disagreement about medical treatment issues, each side attempts to

[27] Assembly Committee on Insurance, August 31, 2012 Hearing

obtain medical opinions favorable to its position, and then counsel for each side tries to convince a workers' compensation judge based on this evidence what the proper treatment is. **This system of "dueling doctors" with lawyers/judges making medical decisions has resulted in an extremely slow, inefficient process that many argue does not provide quality results. Long delays in obtaining treatment result in poorer outcomes, reduced return to work potential, and excessive costs in the system, none of which are good for injured workers**. SB 863 would instead adopt an independent medical review system patterned after the long-standing and widely applauded IMR process used to resolve medical disputes in the health insurance system. Thus, a conflict- free medical expert would be evaluating medical issues and making sound medical decisions, based on a hierarchy of evidence-based medicine standards drawn from the health insurance IMR process, with workers' compensation-specific modifications. The bill contains findings that this system would result in faster and better medical dispute resolution than existing law.

As also observed by the court in *Stevens,* the entire system benefitted from the 2004 reforms (adoption of uniform treatment guidelines using standardized utilization review procedures), and from the 2013 substitution of independent medical review to resolve treatment disputes in lieu of the traditional litigation process.[28].

The legislative history of enactment of Independent Medical Review reflects a clear intent to curtail the Appeals Board's jurisdiction, instead favoring a process relying upon established principles of evidence-based medicine instead of a legal

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[28] "For workers, the reforms ensured that treatment requests would no longer be modified, delayed, or denied except by a physician. "This represent[ed] a significant departure from the [former] process . . ., which permitted an employer or claims adjuster (without review by a physician) to object to a treatment request." (*Sandhagen, supra,* 44 Cal.4th at p. 240.) Workers also secured a guarantee that UR decisions rendered in their favor could not be challenged by employers on medical-necessity grounds. (Cal. Code Regs., tit. 8, § 9792.10.1.) This ensured faster final resolution of these decisions, and it constituted a meaningful curtailment of employers' rights. For employers, the reforms promised to reduce insurance costs by creating uniform medical standards and reducing litigation." *2015 Cal. App. LEXIS 968*

jousting match. Only an interpretation of Labor Code Section 4610.6(d) as directory and not mandatory furthers that legislative purpose. We therefore urge this Court to find in accord with *Stevens*, finding 4610.6(d) directory only.

CONCLUSION

The Petitioner's contention herein [that 4610.6(d) is not merely directory and thus a late IMR decision by the Administrative Director vests the Appeals Board with independent jurisdiction to adjudicate the medical necessity issue] is in direct contravention of Labor Code Section 4610.5(e) (prohibiting utilization review decisions from being reviewed or appealed except via independent medical review), Labor Code Section 4610.6(h) (limiting the grounds under which the Appeals Board may invalidate an independent medical review decision of the Administrative Director), Labor Code Section 4604 (eliminating the WCAB's original jurisdiction over treatment disputes, except as set provided in 4610.5), and Labor Code Section 4610.6(i) (prohibiting the WCAB from making its own determination of medical necessity and instead requiring the matter be remanded to the Administrative Director for another IMR). The contention thus violates both the express statutory provisions and the legislative intent, and should be rejected.

Respectfully submitted,
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LAW OFFICES OF ALLWEISS & McMURTRY
A Professional Corporation

Michael A. Marks, Esq. (SBN 071817)